MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8372)

06938

CERTIFICATE OF DEATH

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: La Plata md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn Infants give residence of mother)
State: md County: Chas
City or town: La Plata md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Henry Eugene Albrittain

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
~~M~~ M	White	Widowed

6.(b) Name of husband or wife
6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): May 7 - 1873

8. AGE: Years	Months	Days	If less than one day
73			hrs. min.

9. Birthplace: La Plata Md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: Geo Henry albrittain
13. Birthplace: La Plata Md
MOTHER 14. Maiden name: Mary Ed Smith
15. Birthplace: La Plata Md
16. Informant: Mrs Lamar Albrittain
Address: La Plata md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-16-46 (month) (day) (year)
Cemetery or crematory: Mt Rest
Location: La Plata md
18. Funeral director: Truett & Ryon
Address: Waldorf md
19. 7-16-46 (Date rec'd by registrar) 19 Julia H. Pacey Registrar

MEDICAL CERTIFICATION

200-400

20. DATE OF DEATH: July 15, 1946, at A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from — 1938, to July 15, 1946
and that I last saw h[im] alive on May 15, 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	minutes
Due to: Generalized arteriosclerosis	10-15 yrs
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: John L. MacKavanagh, M.D. M. D. or other
Address: La Plata, Md Date signed 7-15-46

RECEIVED
JUL 17 1946
BUREAU V.E.

06939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 94a

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: Wicomico
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1915 to 1946
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Wicomico
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Timothey L. Austin

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of ~~husband~~ or wife: Louise Austin
6.(c) If alive, give age: 78 years

7. Birth date of deceased (mo., day, yr.): 10-31-63

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
82	8	24		

9. Birthplace: Farmingdale N.Y. (Nassau Co.)
(Town, county, and state)
10. Usual occupation: Painter
11. Industry or business:
FATHER 12. Name: Gilbert F. Austin
13. Birthplace: Great Neck, N.Y.
MOTHER 14. Maiden name: Elizabeth C. Corbett
15. Birthplace: Deer Park N.Y.
16. Informant: Everet Herbert Austin
Address: Pomfret, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-26-46 (month) (day) (year)
Cemetery or crematory: Bethel
Location: Budds Creek, Md.
18. Funeral director: Hyatt & Ryon
Address: Waldorf, Md.
19. 7-24-46 (Date rec'd by registrar) 19 Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-24 1946 at 2 A M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to 7-24 1946
and that I last saw h alive on 6-10 1946

Immediate cause of death: Congestive Heart Failure — DURATION: 4-16-46
Due to: Coronary Heart Disease & Hypertension
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: [signature] M.D. (M. D. or other)
Address: La Plata Md. Date signed 7-24-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 29 1946
BUREAU V.M.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (175-C)

06940

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: LaPlata Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 4 hrs.
Hospital, institution, or street address where death occurred: Prep. Hem. Hosp. LaPlata Md
How long in hospital or institution? 4 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Chas
City or town: Bel Acton Md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: James Joseph Butler

3.(b) Social Security Number

4. Sex: M
5. Color or race: C
6.(a) Single, married, widowed, or divorced: Single
6.(b) Name of husband or wife:
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Jan 30 - 1923
8. AGE: Years: 23 Months: Days: If less than one day: hrs. min.
9. Birthplace (Town, City, and State): Waldorf Md
10. Usual occupation: Laborer
11. Industry or business:
FATHER 12. Name: Charlie Butler
FATHER 13. Birthplace: Waldorf Md
MOTHER 14. Maiden name: Janet Newman
MOTHER 15. Birthplace: P. Geo Co
16. Informant: Ralph Butler
Address: Waldorf Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-3-46 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Waldorf Md
18. Funeral director: Hutt & Ryon
Address: Waldorf Md
19. Aug 1 1946 (Date rec'd by registrar) M. L. Stokes (Reg. Clerk)

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-31 1946, at 7:30 P.M.
21. I CERTIFY, that death occurred on the date above stated; that I attended deceased from 7-31 1946 to 7-31 1946 and that I last saw him alive on 7-31 1946

	DURATION
Immediate cause of death: Cerebral Hemorrhage	
Due to: Fracture at base of skull	4 hrs.
Due to: Falling from moving truck	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the followiog:
Accident, suicide, or homicide: accident Date of 7-31-46
Where did injury occur? Charles Md
(City or town) (County) (State)
Injured at home, farm, industry, public place (where?): Industry
Means of injury: Fell off moving truck Injured at work? Yes

23. SIGNATURE: [illegible] (M.D.)
M. D. or other
Address: LaPlata Md Date signed 7-31-46

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
AUG 9 1946
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

06941

CERTIFICATE OF DEATH

★ Reg. Dist. No. 105

1. PLACE OF DEATH:
County: Chas
City or town: Waedorf md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: md County: Chas
City or town: Waedorf md
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: George Alfred Chapman

3. (b) Social Security Number: none

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	married

6.(b) Name of husband or wife: annie
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 6 - 1885

8. AGE: Years	Months	Days	If less than one day
61			..... hrs. ..... min.

9. Birthplace: Bryantown md (Town, county, and state)
10. Usual occupation: Farmer
11. Industry or business
FATHER 12. Name: George Alfred Chapman
FATHER 13. Birthplace: Bryantown md
MOTHER 14. Maiden name: Georgiana Rode
MOTHER 15. Birthplace: Bryantown md
16. Informant: Annie Chapman wife
Address: Waedorf md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-3-46 (month) (day) (year)
Cemetery or crematory: St Peters
Location: Waedorf md
18. Funeral director: Hunt & Ryon
Address: Waedorf md
19. July 31 1946 (Date rec'd by registrar) M C Moore Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 30 1946, at 7 am P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 8-6 1944 to 7-30 1946 and that I last saw h... alive on 6-17 1946

Immediate cause of death	DURATION
Coronary Thrombosis	7-30-46
Due to Arteria Sclerosis	8-6-44
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

SIGNATURE: [illegible] M. D.
Address: La Plata Md M. D. or other
Date signed: 7-31-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
AUG 7 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

★ 06942

Reg. Diat. No. 105

1. PLACE OF DEATH: County: Charles; City or town: Bel Alton MD (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or Institution?

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)

State: Md County: Charles

City or town: Bel Alton Md (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Charles Fenwick

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	Col	Single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): 1892

8. AGE: Years: 53; Months; Days; If less than one day: ..... hrs. ..... min.

9. Birthplace: Faulkner MD (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business

FATHER — 12. Name: Thiery Fenwick

13. Birthplace: Chas Co MD

MOTHER — 14. Maiden name: Lou —

15. Birthplace: Chas Co MD

16. Informant: Blanche Brown

Address: Spring Hill Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: 7-13-46 (month) (day) (year)

Cemetery or crematory: St Ignatius

Location: Bel Alton Md

18. Funeral director: Hewitt & Ryon

Address: Waldorf Md

19. 7-11 1946 (Date rec'd by registrar) M L Mouser Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 11 1946, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 4 1946, to July 11 1946, and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Chr. Myocarditis	4 yrs
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury ..... Injured at work?

23. SIGNATURE: Ernest Spencer D. M.D. M. D. or other

Address: Bel Alton Md. Date signed: 7-11-46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

RECEIVED
JUL 12 1945
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06943 105

Reg. Dist. No. .....

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

1. PLACE OF DEATH:

County: Charles

City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? About 2 weeks

Hospital, Institution, or street address where death occurred: —

How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Virginia County: .....

City or town: Keyspilla
(If outside city or town limits, write RURAL and give nearest town)

Street No. .....
(If rural, give LOCATION)

2.(a) If veteran, name war: .....

3.(a) FULL NAME: Noah Griffith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Widowed

6.(b) Name of husband or wife: .....

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years	Months	Days	If less than one day
44-45			..... hrs. ..... min.

9. Birthplace: Colton Va.
(Town, county, and state)

10. Usual occupation: Sawmill man

11. Industry or business

FATHER — 12. Name: William Thomas Griffith

13. Birthplace: Shendoah, Va.

MOTHER — 14. Maiden name: Unknown

15. Birthplace: Va

16. Informant: Earl W. Griffith (nephew)

Address: Indian Head, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-9-46 (month) (day) (year)

Cemetery or crematory: Concord Cemetery

Location: Sheppard Va

18. Funeral director: Hewitt & Ryon

Address: Woodbury Md

19. 7-7 19 46 (Date rec'd by registrar) M L Mowell Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 6, 1946 at about 2:00 to 2:15 P.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from on July 6 19 46, to ..... 19 .....
and that I ~~last saw~~ saw him alive on July 6, 19 46

Immediate cause of death: Probably Coronary occlusion — DURATION: Minutes

Due to: .....

Due to: .....

Other conditions: .....

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Deputy Medical Examiner
James L. MacKenzie, M.D.
M. D. or other

Address: La Plata, Md. Date signed 7-6-46

RECEIVED
AUG 1 1946
BUREAU V. E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-4)

CERTIFICATE OF DEATH

06944

Reg. Dist. No. 100

1. PLACE OF DEATH:
County CHARLES
City or town HUGHESVILLE MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 6 MOS
Hospital, Institution, or street address where death occurred:
HUGHESVILLE AT BROTHERS HOME
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State MARYLAND County CHARLES.
City or town HUGHESVILLE
(If outside city or town limits, write RURAL and give nearest town)
Street No. SWAN'S ROAD OFF HUGHESVILLE
(If rural, give LOCATION)
2.(a) If veteran, name war NONE

3. (a) FULL NAME THOMAS V. JENIFER

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	C	M

6.(b) Name of husband or wife BELLE JENIFER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) APRIL 14 - 1881

8. AGE: Years 64 - Months 3 - Days 13 - If less than one day ..... hrs. ..... min.

9. Birthplace PATUXENT CITY CHARLES, MD.
(Town, county, and state)

10. Usual occupation RETIRED

11. Industry or business FARMER

FATHER 12. Name JOHN H. JENIFER
13. Birthplace ST. MARY'S COUNTY, MD.

MOTHER 14. Maiden name DOLLY BANKS
15. Birthplace WOODVILLE, MD.

16. Informant MASON E. JENIFER
Address HUGHESVILLE, MD.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof July 31 1946 (month) (day) (year)
Cemetery or crematory ST JOHNS
Location NEAR - BENEDICT MD

18. Funeral director ELMER M QUADE
Address Hughesville MD

19. 7-30 1946 (Date rec'd by registrar) Julia H Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH JULY 28 1946 at 5 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from MAY 20 1946 to JULY 20 1946
and that I last saw h. alive on JULY 18 1946 19.....

Immediate cause of death	CURATION
PULMONARY CONGESTION + CEREBRAL ANEMIA	
Due to CARDIAC FAILURE	
Due to CARDIO VASCULAR DISEASE.	
Other conditions —	

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....

Autopsy results .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Alfred R. Lapen M.D.
M. D. or other
Address AQUASCO, MD Date signed July 29 1946

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 31 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-E)

06945

CERTIFICATE OF DEATH

Reg. Dist. No. 100

1. PLACE OF DEATH:
County: Charles
City or town: LaPlata (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 day
Hospital, institution, or street address where death occurred: Physicians Memorial Hospital
How long in hospital or institution? 1 day

2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother)
State: D. C. County:
City or town: Washington (If outside city or town limits, write RURAL and give nearest town)
Street No. 907 E. St. S.E. (If rural, give LOCATION)
2.(a) If veteran, name war: ✓

3.(a) FULL NAME: Andrew A. Kore

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	~~M~~ Single

6.(b) Name of husband or wife:
6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Oct 16, 1895

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
50	8	25		

9. Birthplace: McKeesport, Pa (Town, county, and state)
10. Usual occupation: Bridge Worker
11. Industry or business:
FATHER 12. Name: John James Kore
FATHER 13. Birthplace: U.S.A.
MOTHER 14. Maiden name: Anna Elizabeth ?
MOTHER 15. Birthplace: U.S.A.
16. Informant: Wilma Jean Kore
Address: 1600 Ohio Ave., McKeesport Pa
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7/15/46 (month) (day) (year)
Cemetery or crematory: Arlington Gall Cem.
Location: Arlington Va.
18. Funeral director: W. W. Chambers Co
Address: 617-11th. St. SE. Washington D.C.
19. 7-11-46 (Date rec'd by registrar) 19 Judith H. Carey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7-11 1946, at 10:40 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 7-10 1946, to 7-11 1946
and that I last saw h. alive on 7-11 1946.

Immediate cause of death	DURATION
Cancers of Liver	9-45
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: E. Edelen M.D.
M. D. or other
Address: LaPlata Md. Date signed 7-11-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 15 1946
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

06946

46-F

CERTIFICATE OF DEATH

Reg. Dist. No. 104

1. PLACE OF DEATH:
County Charles
City or town Newburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? Lifetime
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED
(For newborn infants give residence of mother)
State Maryland County Charles
City or town Newburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME John F. Lancaster

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	B	widowed

6.(b) Name of husband or wife Catherine Lancaster
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) March 22 1867

8. AGE: Years	Months	Days	If less than one day
79	4	18	..... hrs. ..... min.

9. Birthplace Newburg (town, county, and state)
10. Usual occupation Laborer (Retired)
11. Industry or business

FATHER
12. Name John F. Lancaster
13. Birthplace Newburg

MOTHER
14. Maiden name Sarah Jane Lancaster
15. Birthplace Newburg

16. Informant Wm. J. Lancaster
Address Faulkner

17. Burial (Burial, cremation, or removal. Which?) Date thereof Aug 1 1946 (month) (day) (year)
Cemetery or crematory St. Thomas Cemetery
Location near Chapel Point

18. Funeral director Hunt & Dyson
Address Waldorf

19. 8/1 1946 (Date rec'd by registrar) William J. Free Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 7-30- 1946 at 9 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6-16- 1946 to 7-30 1946 and that I last saw h.. alive on 7-26- 1946

Immediate cause of death Cancer of Liver — DURATION 2 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE T. L. Hayden, M. D. or other
Address Waldorf Date signed 7-30-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 2 1946
BUREAU V E

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (160-a)

06947

CERTIFICATE OF DEATH

★ Reg. Dist. No. 100

1. PLACE OF DEATH:

County: Charles

City or town: La Plata

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Physicians' Memorial Hospital

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State: Maryland County: Charles

City or town: Indian Head,

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: George Lawrence Oliver

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	white	single

6.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1946

8. AGE: Years | Months | Days | If less than one day: ..... hrs. 35 min.

9. Birthplace: La Plata, Charles, Maryland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER — 12. Name: George Ward Oliver

FATHER — 13. Birthplace: Washington, D C.

MOTHER — 14. Maiden name: Carlene Shewbart

MOTHER — 15. Birthplace: Alabama

16. Informant: George Oliver

Address: Indian Head, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 8-1-46 (month) (day) (year)

Cemetery or crematory: Yard of home

Location: La Plata, Md.

18. Funeral director: Huntt & Ryon

Address: Waldorf, Maryland

19. 8-1-46 (Date rec'd by registrar) 19.. Julia H. Penny Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31, 1946 at 9:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... on July 31 1946 to ..... 19.. and that I last saw him alive on July 31 1946

Immediate cause of death	DURATION
Cerebral hemorrhage	35-40'
Due to: Died during childbirth	
Due to: Persistent posterior presentation, non-deliverable except with manual + forceps rotation to R.O.A.	

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Jas. L. MacKavanagh M.D. M.D. or other

Address: La Plata, Md. Date signed 7-31-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
AUG 3 1945
BUREAU V E

06948

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94)

CERTIFICATE OF DEATH

Reg. Dist. No. 10

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 34 years
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Richard Henry Rison

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Male	White	Married

6.(b) Name of husband or wife: Mollie Rison
6.(c) If alive, give age: 43 years

7. Birth date of deceased (mo., day, yr.): January 28, 1894

8. AGE: Years	Months	Days	If less than one day
52	6	0	hrs. min.

9. Birthplace: Cherry Hill Md
(Town, county, and state)
10. Usual occupation: Motorman (Electric)
11. Industry or business: U.S.N.P.F.
FATHER 12. Name: Henry Rison
13. Birthplace: Md.
MOTHER 14. Maiden name: Mary Sanrod
15. Birthplace: Md
16. Informant: Mrs. Mae Stubbs
Address: Indian Head. Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-30-46 (month) (day) (year)
Cemetery or crematory: Woodbine Cemetery
Location: Mt Manassas Va.
18. Funeral director: Hunt & Ryon
Address: Waldorf. Md
19. 7-29-46 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 28 19 46 at 1A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Coronary embolism	1 day
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank G. Swan M.D. M. D. or other
Address: Indian Head Md Date signed 7/29/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

RECEIVED
AUG 1 1944
BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

CERTIFICATE OF DEATH

06949

Reg. Dist. No. 106

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: Home of Midwife (Mary Woodland Thomas)
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Indian Head
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Julian Smith

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M/C	Colored	Single

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 31, 1946

8. AGE: Years | Months | Days | If less than one day: 6 hrs. 30 min.

9. Birthplace: Indian Head (Town, county, and state)

10. Usual occupation: Infant

11. Industry or business

FATHER
12. Name: Julian L. Smith
13. Birthplace: Washington D.C.

MOTHER
14. Maiden name: Mary L. Spriggs
15. Birthplace: Pomfret Md

16. Informant: Mary C. Smith
Address: Port Tobacco, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 1, 1946 (month) (day) (year)
Cemetery or crematory: St Catherines Church
Location: Mc Conchie, Md

18. Funeral director: Penny & Cofer
Address: Mason Springs - Md

19. 7/31 (Date rec'd by registrar) 19 46 Eddy Price Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 31 19 46, at 12 Noon M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death	DURATION
Asphyxia Neonatorum	
Due to: Prematurity	1 month
Due to:	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Julian L. Smith M. D. or other
Address: Indian Head Md Date signed: July 31 1946

RECEIVED
AUG 8 1946
BUREAU V S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

CERTIFICATE OF DEATH ★

06950

Reg. Dist. No. 100

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:

County: Charles

City or town: Benedict Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State: Md. County: Charles

City or town: Benedict
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME: Wills, Agnes A.

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	Colored	Widow.

6.(b) Name of husband or wife: Joseph L. Wills

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): ~~at~~ March 28, 1902

8. AGE: Years	Months	Days	If less than one day
44	3	11	hrs. min.

9. Birthplace: Aquasco, Pr. George Co., Maryland (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Housewife

FATHER
12. Name: Marcellus Washington
13. Birthplace: Charles County

MOTHER
14. Maiden name: Rose Chase
15. Birthplace: Pr. George Co.

16. Informant: Joseph Wills
Address: Benedict - Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof 7-13-46 (month) (day) (year)

Cemetery or crematory: St Peters

Location: Waldorf

18. Funeral director: ELMER M Rusde

Address: Hughesville Md

19. 7-12 1946 (Date rec'd by registrar) Julia H. Posey Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: July 10 1946, at 6 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 1946 to July 10 1946 and that I last saw her alive on July 10 1946

Immediate cause of death	DURATION
Myocarditis, Acute	
Due to: Hypertensive Cardio-Vascular Disease.	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: Louis C. Gaeles M.D.
M. D. or other

Address: Hughesville, Md. Date signed: July 12, 1946

RECEIVED
JUL 15 1946
BUREAU V. R.

Evidence for correct spelling of surname is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

06951 105

Reg. Dint. No.

FILM No. I 06 JUL 22 1946

1. PLACE OF DEATH:
County: Charles
City or town: Rock Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md County: Charles
City or town: Rock Point, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME: Edward Thomas (Zernia)

3. (b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M	W	Married

6.(b) Name of husband or wife: Josephine (Zernia)
6.(c) If alive, give age: 57 years
7. Birth date of deceased (mo., day, yr.): June 10, 1887

8. AGE: Years	Months	Days	If less than one day: hrs.	min.
59	1	28		

9. Birthplace: Chapel, Md. (Town, county, and state)
10. Usual occupation: Photo printer
11. Industry or business

FATHER
12. Name: William Zernia
13. Birthplace: Md.

MOTHER
14. Maiden name: Minnie Zernia
15. Birthplace: (Zernia)

16. Informant: Josephine Zernia
Address: Rock Point Md 7-11-46

17. Burial
(Burial, cremation, or removal. Which?) Date thereof 7-11-46 (month) (day) (year)
Cemetery or crematory: Cedar Hill
Location: Beltsville, Md.

18. Funeral director: Hunter & Ayres
Address: Waldorf

19. 7-10 1946 W. C. Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: 7 — 8 — 1946, at 10:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..., to ..... 19...
and that I last saw h... alive on ..... 19...

Immediate cause of death	DURATION
a Coronary Heart Occlusion	2 hrs.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: J. L. Hyde M. D. or other
Address: Waldorf Date signed 7-8-46

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
JUL 11 1946
BUREAU V B